SP/PHC
Strategic Purchasing for Primary Health Care

FINANCIAL INTEGRATION OF LOCAL HEALTH SYSTEMS AS ENVISIONED IN THE UHC LAW

THINKWELL

EXECUTIVE SUMMARY

One of the key features of the Philippines Universal Health Care (UHC) Law is the restructuring and integration of the financing of province- or city-wide local health systems that will govern health care provider networks comprised of primary to tertiary facilities. In the three years since the law's enactment, the Department of Health (DOH) and PhilHealth have released policies to guide the implementation of financial integration. This brief explores how the financial integration of local health systems, as mandated in the UHC Law, can improve health financing in the country and provide recommendations for its successful implementation. ThinkWell's analysis shows that the financial integration of local health systems has the potential to improve the quality of care, but only if several processes are fine-tuned. To achieve this, stakeholders must continue collaborating to model, test, gather evidence, and forge a consensus around continuous improvement, allowing the sector to introduce and institutionalize evidence-based health financing reforms.

INTRODUCTION

The Philippines Universal Health Care (UHC) Law states that province- and city-wide health systems (PCWHS) must demonstrate financial integration starting in 2023. It is currently optional for local government units (LGUs) to integrate into PCWHS, but the UHC Law passed in 2019 mandates that PCWHS first establish managerial and technical integration of their health systems within the first three years (Figure 1). The first involves forming a unified governance mechanism through a functional province-wide health board (PHB) or city-wide health board (CHB) with an integrated management system. Under the second, PCWHS must offer synchronized health delivery by ensuring a functional referral system for health care provider networks comprised of primary to tertiary facilities. PCHWS must also deliver an active, coordinated disaster risk reduction response, epidemiologic surveillance, and effective health promotion programs. Finally, financial integration is defined as the consolidation of financial resources exclusively for health service and systems development under a single planning and investment strategy. The law also describes the creation of a Special Health Fund (SHF), where PCWHS can pool and earmark resources for health. The DOH and PhilHealth have already released policies that guide how financial integration will occur and are preparing for implementation.

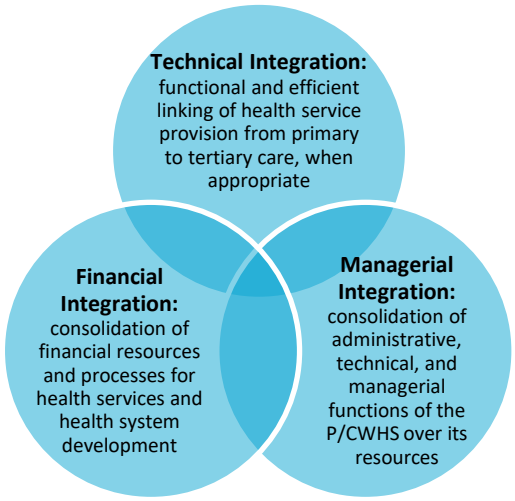

Figure 1. Three areas of local health system integration
Source: Authors, adapted from (Department of Health 2020)

Box 1. A summary of the mandate of the UHC Law for local health system integration

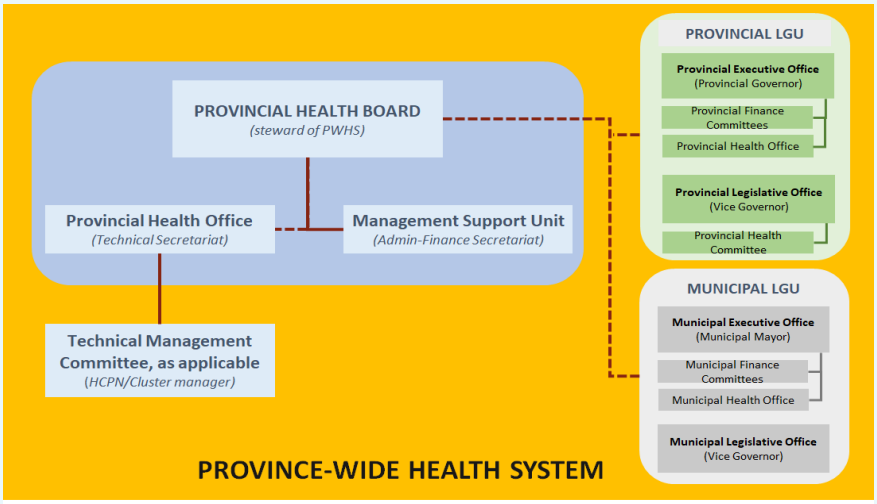

Figure 2. Sample organizational structure of a province-wide health system
Source: Authors, adapted from DOH AO 2020-0021

Republic Act No. 11223, or the UHC Law, is a landmark legislation passed by the Philippines in 2019 that introduces structural and functional changes in health financing, service delivery, and governance. One such reform of the law is to encourage LGUs to integrate into the province- or city-wide health system (PCWHS) to improve the health of an area's entire population by coordinating all aspects of health care, including population-based and individual-based (or clinical) services. PHB or CHB governs each PCWHS with representation from participating LGUs, the private sector, and other stakeholders in the local health system. One key task of the board is the supervision of a special health fund (SHF) through a secretariat called the Management Support Unit (MSU). All facilities controlled by the LGU are organized into one or more health care provider networks (HCPNs), which are overseen by a Technical Management Committee (TMC). There are multiple configurations to the relationship of each PCWHS to HCPN. Each PCWHS can manage just one HCPN (PCWHS-HCPN) or multiple HCPNs. On the other hand, facilities participating in the HCPN can go outside of its geographical bounds. The law also mandates PhilHealth payments for facilities in an HCPN and other revenue flow into the SHF to encourage this integrated approach. By 2025, the integration of the local health system will be assessed by an independent study commissioned by the Joint Congressional Oversight Committee. If they receive a positive recommendation, all local health systems will be recommended to integrate.

*A glossary of some of the key terms used in this brief can be found in Annex A.

This brief illustrates how these policies on financial integration will change the financing of health services at the subnational level. First, the existing health financial arrangements at the subnational level are described, as well as past efforts to reform them. Next, how local health financing will change under the UHC Law is examined. Finally, the challenges and opportunities that the implementation of the Law presents are discussed, and recommendations are made for the way forward.

METHODOLOGY

This brief was developed from data obtained using qualitative methods: an archival review of policies on financial integration in the UHC Law, the peer-reviewed and grey literature on financial integration, and key informant interviews. A draft version of this brief was shared with key local experts for validation and comments. Their feedback is incorporated into the final version.

FRAGMENTATION OF LOCAL HEALTH FINANCING IN THE PHILIPPINES: A BACKGROUND

Currently, each LGU in the country manages multiple sources and pools of funds to provide health services to its constituents. The Local Government Code (LGC) of 1991 granted fiscal and administrative autonomy for each LGU in the delivery of health functions, including the authority and responsibility for local health facilities and the direct provision and management of health services, such as public health, promotive, and preventive health care programs (Dayrit et al. 2018; Cuenca 2018). Each level of government has its own geographical and technical scope regarding health services and responsibilities (Table 1). In terms of organization, elected local chief executives (LCEs) govern each LGU and serve as their respective Local Health Boards (LHB) chairs. The LHB is tasked with proposing a health budget for approval of their LCE (Dayrit et al. 2018).

Table 1. Devolved health functions by the level of government

LGU Level (2022)[1]	Technical Responsibility
Barangay Total #: 42,046 Ave Pop'n: 2,402	Maintenance of barangay health station (BHS); provision of basic health care services and daycare services for the population within geo-political boundary
Municipality Total #: 1,488 Ave Pop'n: 43,299	Maintenance of rural health unit (RHU) and staff; implementation of programs and projects on primary health care, maternal and child care, and communicable and non-communicable diseases for the population within geo-political boundary
Independent Component and Component City Total #: 113 Ave Pop'n: 189,883	Same as above for RHUs
Province Total #: 81 Ave Pop'n: 1,053,896	Maintenance of hospitals and provision of secondary and tertiary health services for the population within a geo-political boundary; coordination of health service delivery of the municipalities and component cities within its jurisdiction
Highly Urbanized City Total #: 33 Ave Pop'n: 701,423	Same as above for BHS, RHUs, and hospitals within its jurisdiction

Sources: (J. Capuno et al. 2018; Cuenca 2018)

This structure leads to inequity in the availability of resources in each LGU. Most LGUs continue to depend on intergovernmental transfers from the national budget called the National Tax Allotment (NTA)[2] to finance their spending for health services. The size of the NTA depends on the income classification of the LGU and factors such as population, land density, and geographic size (Uchimura 2012). The formula has no equalization or adjustment factors related to risk or demographic profile. The funds allocated to health are subject to variability in budgeting because the NTA does not set specific conditions or allocations for programs or expenditures. The country's national health insurance agency PhilHealth reimburses LGU-owned facilities that are accredited. The funds are regarded as non-tax revenues of the LGU and are not necessarily earmarked for use by the facilities or indeed for health (Nuevo et al. 2022). Accredited health facilities are generally located in more urban or affluent areas and can claim more PhilHealth payments (Flaminiano et al. 2022). In general, these are primarily for inpatient care. Overall, LGU financing tends to be regressive across the LGUs, where lower-income areas tend to allocate and spend less on health. In 2018, the per capita health expenditure of first-class provinces (Php 5,029/US$ 100) was larger compared to fourth-class provinces (Php 2,309.49/US$ 50) and fifth-class provinces (Php 767.97/US$ 16), respectively (Nuevo et al. 2022).[3] Figure 3 also illustrates the current expenditure for Health and Nutrition for Provinces, Cities, and Municipalities for 2019, where some cities in the greater Metro Manila have higher expenditure than some provinces.

[1] PSA data as of June 30, 2022

[2] This was previously called Internal Revenue Allotment but was renamed because of the landmark Supreme Court ruling on the Mandanas-Garcia petition of 2018.

[3] Provinces, cities and municipalities are classified according to average annual income based on the previous four calendar years

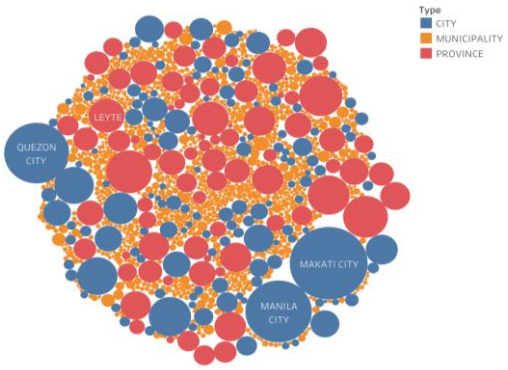

Figure 3. Current expenditure for health and nutrition for provinces, cities, and municipalities for 2019

Source: BLGF, 2019

The effective utilization of different funding pools poses significant obstacles due to their divergent nature. Funds from the NTA and local income are pooled into the general fund of the LGU and are considered during the annual financial planning cycle of the LGUs (Nuevo et al. 2022). In contrast, PhilHealth and DOH grants are pooled into different trust funds for each LGU. Because of the unpredictable nature of these funds and inadequate awareness about their availability on the part of the local finance committee, they are not often considered by LGUs during the annual financial planning process for the delivery of health services and local implementation of health policies. Each individual benefit package of PhilHealth may contain stipulations on utilizing the reimbursement by the LGUs, which complicates their execution. For example, the Primary Care Benefit package of PhilHealth states that 80% of revenues should be for operational costs, while only 20% is for personnel (PhilHealth 2012). Conversely, the absence of policies regarding permissible charges for the Interim Reimbursement Mechanism caused some confusion on its utilization (Wee-Co, Apostol, and Ravishankar 2022). For funding from the DOH, the DOH regional health offices co-manage the funds on behalf of the LGUs because of the poor absorptive capacity of LGUs.

Fragmentation in the local health financing system contributes to inefficiencies in the health sector. Fiscal coordination has been and continues to be limited across LGUs (Department of Health 1999). Higher spending for one municipality tends to increase spending for a nearby municipality and similarly between provinces and adjacent municipalities (Kelekar 2013; Kelekar and Llanto 2015). This might be due to potential competition for health care inputs such as health human resources sourced within the same limited general population group. The current decentralized set-up of financing for health services leads to spatial spillovers and missed opportunities for economies of scale (J. J. Capuno 2017). For example, a study shows that DOH-retained hospitals were generally more efficient at procuring medicines than provinces, while provinces were more efficient than municipalities (Ball and Tisocki 2008). Although it was inconclusive if this was due to volume, the study also speculated that this might be due to variable efficiency of the procurement process at the lower level due to a lack of management and procurement skills and absence of structural factors (i.e., established procedures for procurement, audit and oversight mechanisms), which leads to greater risk of corruption.

Additionally, the geographical division of LGUs has led to challenges in implementing a referral system across levels of facilities. Patients continue to seek services from the nearest facilities of better quality without consideration of its level or its ownership, or at times, despite its cost. Despite the DOH's efforts to implement referral standards, there is a lack of coordination between primary levels of health care and specialty interventions across different types of facilities (Romualdez et al. 2011). Technical supervision, health referral communications, sharing of health information, joint health planning, and cost-sharing are needed to operationalize a referral system. However, because of jurisdiction limits, there is no clear accountability to ensure such a mechanism (Grundy et al. 2003; NCPAG-CPED 2014; Cuenca 2018).

Various stakeholders have tried to push for policies to address the fragmentation of the country's health system. Since 1992, there have been many reviews and attempts to amend the LGU Code, but only piecemeal modifications have passed as law (J. J. Capuno 2017). Both the executive and the legislature have tried to

renationalize the health sector in parts (e.g., renationalization of some hospitals) or completely (Paris 2019; Laforga 2021; Senate of the Philippines 2017; Cepeda 2021). Over the years, the DOH has also tried establishing service delivery networks (SDNs) for specific health services such as maternal and child health. For example, the Sin Tax Law and the Responsible Parenthood and Reproductive Health Act mandated the formation of SDNs to achieve better health care (Government of the Philippines 2012a; 2012b). The Philippine Health Agenda during the Duterte Administration targeted the operationalization of SDNs in three regions during the first 100 days (Department of Health 2016). The DOH also released a policy framework for redefining SDNs to guide their organization. These various attempts have been limited so far in terms of functionality or sustainability (Department of Health 2017).

Introducing the concept of Inter-Local Health Zones (ILHZs) was one of the most notable interventions addressing the fragmentation of local health systems. In 2000, the President of the Philippines signed an executive order that mandated the creation of ILHZs or well-defined populations (by the level of governance) in a rural or urban area and all institutions and sectors whose activities contribute to improved health care delivery (Government of the Philippines 2000). This was expounded in Administrative Order 2006-2017, where ILHZs were defined as "any form of organized arrangement for coordinating the operations of an array and hierarchy of health providers and facilities serving a common population within a local geographic area under the jurisdictions of more than one local government … which includes the following critical operating elements, namely: 1) primary health providers; 2) core referral hospital and 3) end referral hospital." (Department of Health 2006).

Different approaches have emerged to administer the common health fund for ILHZs, underscoring the significance of financial support. Some ILHZs maintained an account as a common health fund by registering with the Securities and Exchange Commission (Lorenzo et al. 2001). Funds in this arrangement were disbursed according to the integrated work and financial plan. Some common health funds were maintained by one collaborating LGU as agreed upon by participating LGUs and managed by the ILHZ Technical Management Committee (TMC). The ILHZ Health Board and the TMC maintained separate books of account and kept financial records available for monitoring and auditing by an authorized agency for the common fund. Funds going into the common fund were also variable in amount. Some participating LGUs pledged amounts to reflect the financial position of each of the participating towns. In some pilots, external funding was provided by agencies such as AusAID and ADB (Lorenzo et al. 2001). This jump-started ILHZ formation and facilitated the functionality of participating facilities. Participation in the PhilHealth Indigent Program[4] was a critical component of many of these ILHZs as a mechanism to ensure financial protection for their beneficiaries and to generate revenues for health for their LGUs (Wee-Co et al. 2021). Unfortunately, the implementation of ILHZs never scaled up—likely due to the lack of institutional funding mechanisms to support their operation—though there is little documentation and evaluation of these reforms.

FINANCIAL INTEGRATION OF LOCAL HEALTH SYSTEMS WITH THE UHC LAW

The UHC Law has key legal mandates that affect key health financing processes of subnational government and ease financial integration of health services. While the ILHZ was a natural catchment area agreed upon by several LGUs, the UHC law took a more geo-political definition of integrated health systems as those within the province- or city-wide settings. This aligns and eases the creation of governance mechanisms with existing positions available because of the devolved set-up of the country. As mentioned, the UHC Law was also able to institutionalize the creation of the SHF. The UHC Law mandates for

[4] In 1997, PhilHealth introduced the indigent or sponsored program, where premiums of these select beneficiaries—usually those belonging to the poorest quintile—were paid for by the national government, local government units (LGUs), or the private sector.

PhilHealth and DOH that a PCWHS has an SHF before they can be contracted. For PhilHealth, the UHC Law mandates it to consolidate all income derived by its payment to the LGUs via the SHF, thus ensuring a steady source of funds going into the SHF. The law also instructs integrated province- and city-wide health systems to use the Local Investment Planning for Health (LIPH) and the Annual Operations Plan (AOP) as tools for planning and the basis for budgeting and allocating resources to their integrated system. What follows is a discussion of the potential changes that financial integration will likely foster with respect to subnational health financing, as well as provide recommendations for improving their implementation, which are summarized in Table 2.

Implementing financial integration is further operationalized by policies that the DOH, PhilHealth, and other government agencies have released or are planning to finalize to comply with the UHC Law. The DOH, Department of Budget and Management (DBM), Department of Finance (DOF), Department of Interior and Local Government (DILG), and PhilHealth have released a joint memorandum circular on the SHF's allocation, utilization, monitoring, accounting, and accountability (Department of Health 2021). PhilHealth released a circular in 2022 to pilot or sandbox contracting primary care provider networks for the Konsulta benefit package[5] (PhilHealth 2022). However, implementation of the Konsulta sandbox has been delayed to the middle of 2023 to ensure that audit mechanisms are also in place. In 2020, the DOH also released initial policies to illustrate how it will contract PCWHS, specifying that terms of partnership (TOP) will be the legal instrument to contract PCWHS (Department of Health 2020). Grants and other policies from the DOH and other government agencies continue to be designed and will shape the financing system and processes of integrated PCWHS.

The UHC Law requires the PHB and CHB to assume full responsibility for the SHF with support from a Management Support Unit (MSU). The PHB/CHB is composed of the local chief executive of the province or city, the chief health officer, the legislative committee member on health, the DOH representative, representatives of component municipalities or cities in the integrated system, and representatives of the indigenous community and other organizational stakeholders (Figure 4). The MSU is tasked to be the administrative secretariat and, at a minimum, is composed of an accountant, administrative officer, and liaison officer. The DOF, DBM, PhilHealth, and other relevant government bodies are responsible for providing public financing management (PFM) training to P/CHB and MSU members.

These P/CHBs, with the assistance of the province or city health office, will plan, budget, and allocate funds for the integrated health system. They will formulate the LIPH and the AOP for the PCWHS that will then serve as the basis for the SHF budget preparation, project procurement and management plan, and annual procurement plan. Each LGU will continue to fund mandatory expenses of its health facilities, remuneration of existing healthcare workers, and expenses of its health board and these costs must thus be included in the LGU plans. On the other hand, PCWHS can use funds in the SHF for the health

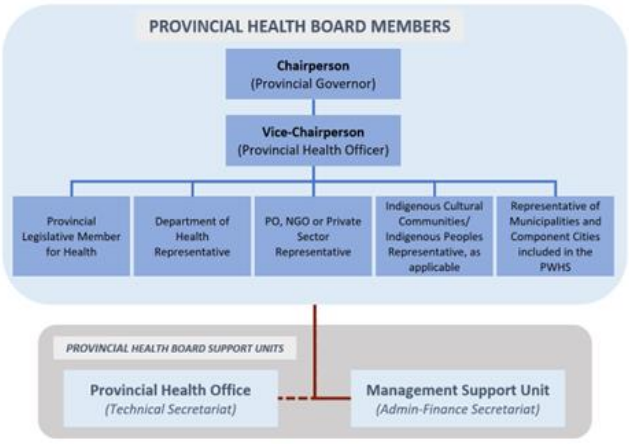

Figure 4. Composition of the province-wide health board (PHB)
Source: Authors, adapted from RA 11223 (UHC Law)

[5] Benefit package of PhilHealth introduced in 2020 to pay for select primary care services via capitation.

system operating cost, capital investments remuneration of additional health care workers, incentives for both existing and additional health care workers, and other additional costs. Ensuring coordination of individual LGU financing and utilizing the SHF may occur at the PHB/CHB level.

The pooling of funds from various sources into the SHF is a critical but challenging component of financial integration in the Philippine health care system (Figure 5). Funds envisioned to be pooled into the SHF include financial grants from the DOH and other national agencies, PhilHealth income, a voluntary counterpart from the local government, and other CSOs and development assistance sources. PhilHealth is envisioned to be the largest source of funds that will go into the SHF, but all these sources are necessary. These various funds should be allocated to local health system priorities, allowing for a more equitable and efficient allocation of resources. By ensuring that resources are pooled, allocated, and utilized effectively, the SHF plays a critical role in achieving financial integration and, ultimately, in ensuring that all Filipinos have access to good-quality and affordable health care services.

The contractual arrangement with the funder—along with the health investment plan of the PCWHS, DOH policy guidelines, and existing government PFM rules—will determine the execution of the monies inside the SHF for the PCWHS. For example, the DOH guidelines on the SHF list allowable expenses to be charged. PhilHealth's circular on contracting networks for Konsulta states that PCWHS must submit fund utilization reports before additional money will be sent to the SHF. While PCWHS still needs to be contracted by either PhilHealth or DOH to be able to see how the financing will be translated into inputs—such as health care workers, medicines, facilities, and services—one can foresee that there is potential for pooled execution of these resources to address system-wide gaps. For example, PCWHS may do pooled procurement of medicines across LGUs within the same province, hire additional health care workers to meet the objectives of the PCWHS, or design incentives for them. As mentioned, there is a need for individual LGUs to continue funding existing staff and pay for the recurrent operational cost of each facility. However, current PFM rules, including government procurement policies, limit flexibility and responsiveness in the execution of the funds in the SHF, particularly in engaging the services of the private sector. With this, there is a continuous need to amend policies and redesign incentives to ensure the effective utilization of the funds in the SHF.

The UHC Law has introduced new mechanisms to strengthen the monitoring and evaluation of funds for the health system as it transitions toward integrated health delivery. For example, the Commission on Audit (COA) is preparing its guidelines for accounting for the SHF based on the design of incentives from PhilHealth and DOH. It must improve on these if new SHF funding mechanisms are applied. The law also states that an SHF tracking system must be developed to help various agencies monitor the funds allocated for health. This must be interoperable with the existing LGU Integrated Financial Tools System of the Bureau of Local Government Finance of the DOF, which has already created SHF modules. They are still awaiting the issuance of the COA Guidelines prior to the implementation of these modules. There is a need to fast-track its development and implementation. The country can also consider strengthening other mechanisms that will ensure adequate monitoring of funds for health at the subnational level, such as by engaging budget advocacy groups and watchdogs at this level.

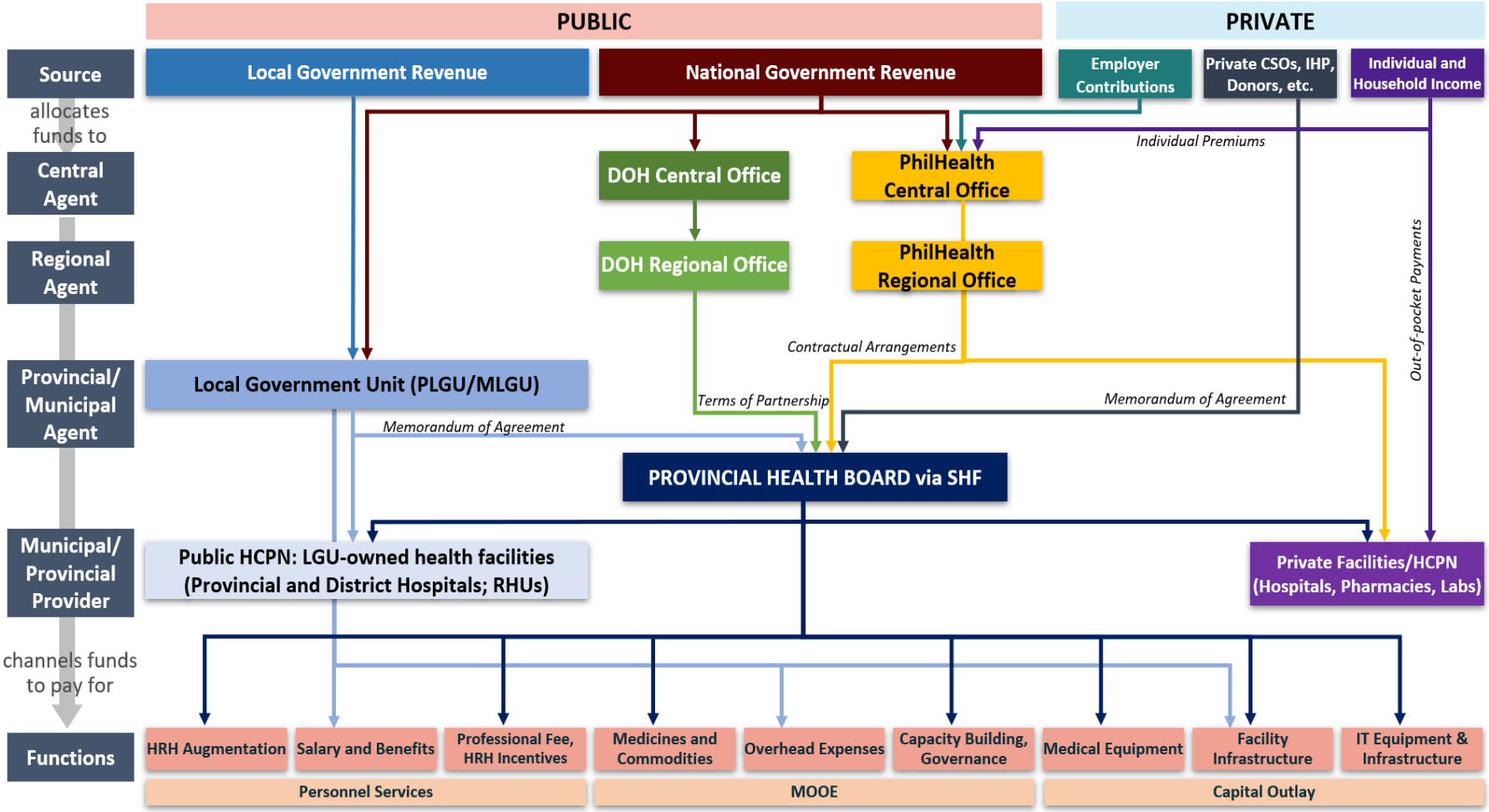

Figure 5. Health care funding flow via the SHF
Source: Authors

CSO: Civil Society Organizations; IHP: International Health Partners

If integrated funds are to be a model for the future, attention needs to focus on how they can be implemented in practice, and it will be important not to underestimate the efforts required to forge and maintain the relationships that underpin the financial mechanisms.
--Mason et al., 2015

DISCUSSION

Globally, there is interest in the potential of financial integration across health facilities, health systems, or services outside of the health sector to introduce more efficiencies and improve the quality of services and outcomes but results thus far are mixed. In the U.S., health care organizations are becoming more extensive and financially integrated—most hospitals and nearly half of all physicians belong to networks and group practices as an integrated system. However, evidence points to more costly care without better quality (Neprash et al. 2015; Fisher et al. 2020). In Scotland, the Integrated Resource Framework was developed to shift the balance of care toward preventive care and ensure health and social services integration. An evidence review on financial integration across health and social care programs showed that it was difficult to nuance the effect of the different types of financial integration mechanisms; in general, its effects on outcomes and cost are mixed (Mason et al. 2015). Although the case for financial integration has not been demonstrated yet, the study stressed the need to continue to refine such approaches, improve their implementation, and study the effects.

For the Philippines, it is vital to continue understanding what is meant by the financial integration of local health systems and what it would mean for the health system and improvement in health outcomes. Integration can be understood according to the domain, level, and degree (Grépin and Reich 2008) (Annex B). It can also be understood according to the mechanism of financial integration (Mason et al. 2015) (Annex C). Current policies only define financial integration as an integrated approach to consolidating funds for the SHF of PCWHS. This analysis shows that a variety of PFM processes and policies influence the integrated and practical use of local funds for health. Each of these may have implications for the effectiveness of the health financing ecosystem of a PCWHS.

While the Philippine Government has made substantive advances in policy work to shape financial integration, emerging gaps and challenges in national policies and planned local adaptation must be addressed. The country must implement more agile policymaking processes and ensure a faster feedback-to-policy improvement loop if it wants to hasten the achievement of UHC. Feedback and clarification are emerging from the LGUs regarding existing policies, which must already be addressed. For example, guidance on crafting the LIPH should be continuously enhanced to consider the health sector's new fund sources and priorities. Contracting PCWHS via the SHF requires that some existing programs, such as the Health Facility Enhancement Program,[6] be redesigned with this in mind. Gradual and selective implementation should be started to test how these policies interact. The planned sandbox for the Konsulta network contracting is an excellent way to test some of these policies. It is very important to document all the learning and challenges so that these can be addressed accordingly during the full implementation. In doing so, insights on improving local health financing integration policies can already be generated in preparation for a more robust implementation at the subnational systems as the

[6] The DOH Health Facility Enhancement Program (HFEP) is a health program in the Philippines that aims to improve the quality and accessibility of health services in public health facilities. It provides funding for the construction, renovation, and upgrading of health facilities, as well as the acquisition of medical equipment and supplies. <https://sdg.neda.gov.ph/health-facilities-enhancement-program-hfep/>

DOH and PhilHealth continue to improve their incentives.

The Philippine Government must also ensure it can address external factors that may deter the effective implementation of UHC. Fisher and colleagues (2012) theorize that the dismal effect of financial integration on quality may be due to factors such as a lack of enabling environment to motivate change (e.g., design of financial and regulatory incentives), the capacity for innovation of significantly larger organizations, and variations in quality measures of the individual facility. These are similar challenges that the country faces as it starts the implementation of financial integration of local health systems. DOH, PhilHealth, and other agencies must redesign their policies and incentives to influence the behavior of this new "agent"—health care provider networks in PCWHS—toward improved access and delivery of high-quality services for all beneficiaries. The literature documents the barriers to adopting financial integration, such as cultural, governance and political differences, and difficulties in aligning operational mechanisms, such as performance frameworks, priorities, and linking individual information systems. Emerging PCWHS are also encountering these challenges; thus, intensive handholding and support are needed for smoother integration. To enjoin other provinces and cities to integrate, there needs to be a clear demonstration of value and concrete benefits from the initial pilots of financial integration. Finally, there is also a need to help PCWHS address the fundamental service gaps and capacities of individual health facilities and systems. Foremost of these are gaps in health human resources and facilities upgrading.

With all the challenges and complexities that need to be addressed, is the financial integration of local health systems critical in attaining UHC in the country? Roberts and colleagues opine that "Even huge increases in funding will not suffice, unless and until nations have in place the institutions and infrastructure to use such funds effectively" (Roberts 2008). There is growing recommendation for reforms that will allow for the use and accountability of funds for health services and responsiveness to various purchasing signals (de Walque et al. 2022). The WHO also highlights the importance of improving the quality of PFM systems for health in attaining UHC (Barroy et al. 2018). Improving the predictability and adequacy in the budget envelope, ensuring alignment of allocation with sector priorities, improving budget execution, and allowing for a certain degree of flexibility and responsiveness of the budget can lead to UHC by ensuring better transparency, accountability, efficiency, and equity in the use of public resources (Figure 5). The current mandate of the UHC Law toward financial integration of local health financing creates the window to introduce PFM reforms for health at the subnational level. This can potentially strengthen the capacity to translate financing into providing quality services to its constituents. Various stakeholders must collaborate to test, model, gather evidence, and create a consensus allowing the sector to continue introducing and institutionalizing evidence-based health financing reforms.

SUMMARY

The Philippine UHC Law provides an opportunity to jumpstart the integration of the health system across various dimensions. In particular, the law ensures that local health financing systems can be strengthened and re-channeled so that UHC can come to fruition. The journey ahead is long and challenging, but the promise of consolidated efforts to ensure the fruitful implementation and improvement of its initial forays—leading to its assessment in 2025 and institutionalization—is real.

Recommended citation:

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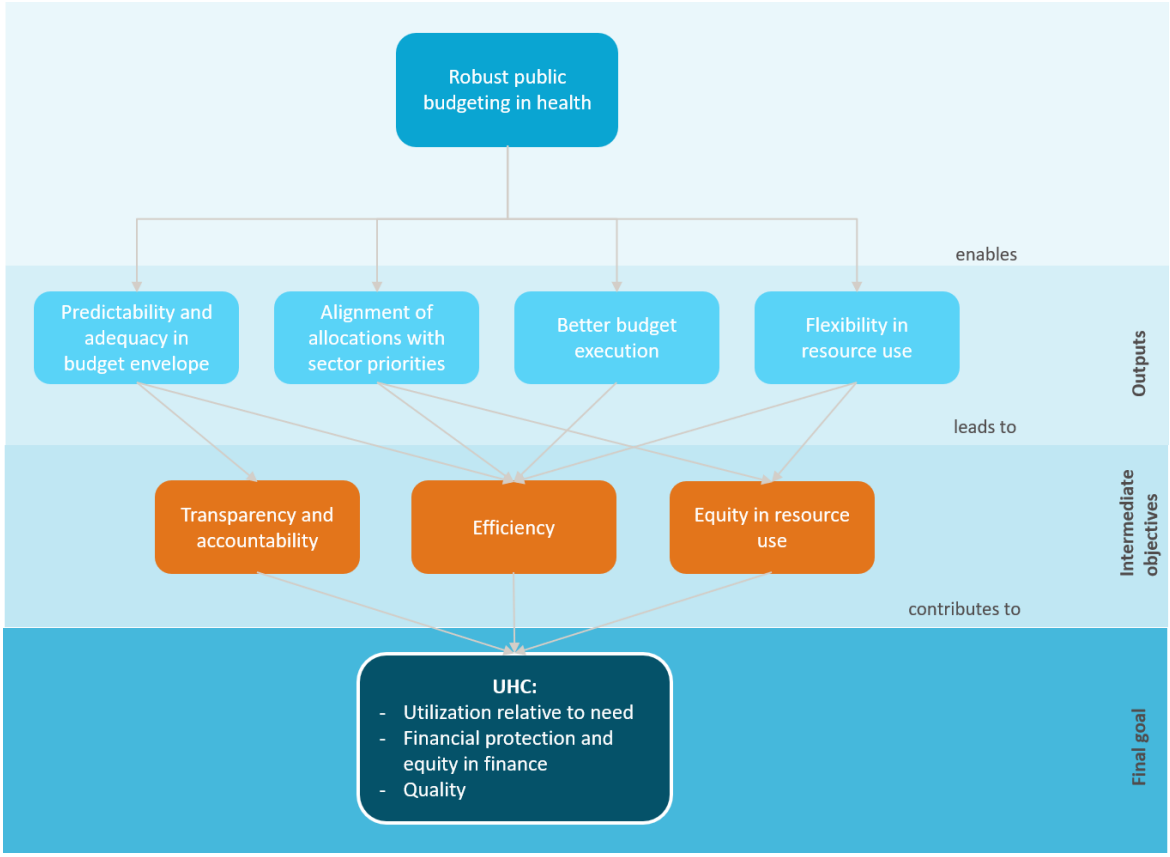

Figure 5. Robust public budgeting: critical enabling factor for UHC

Source: (Barroy et al. 2018)

The Strategic Purchasing for Primary Health Care (SP4PHC) project aims to improve how governments purchase primary health care (PHC) services, with a focus on family planning (FP) and maternal, newborn, and child health. The SP4PHC project is focused on purchasing reforms in six countries: Burkina Faso, Indonesia, Kenya, Pakistan, the Philippines, and Uganda. The project is supported by the Bill & Melinda Gates Foundation and implemented by ThinkWell in collaboration with country governments and local research partners.

In the Philippines, the project provides technical assistance to national and local governments to strengthen health purchasing policies and practices in support of the implementation of the Universal Health Care (UHC) Law enacted in 2019. To demonstrate applicability, incubate innovative ideas, and generate evidence, ThinkWell supports UHC Integration Sites (UIS) in the provinces of Antique and Guimaras.

For more information, please visit our website at **https://thinkwell.global/projects/sp4phc/**.

For questions, please write to us at **sp4phc@thinkwell.global**.

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ANNEX A. GLOSSARY OF UHC TERMS

SOURCE: SHF JMC 2021-001; DOH AO 2020-0021, 2020-0019

ACRONYM	UHC TERM	DEFINITION/DESCRIPTION
AOP	Annual Operational Plan	Yearly operational translation of the LIPH detailing the programs, plans, and activities (PPAs), and systems interventions to be implemented in the P/CWHS in a particular year.
HCPN	Health Care Provider Network	A group of primary to tertiary care providers, whether public, private, or mixed, offering people-centered and comprehensive care to its catchment population in an integrated and coordinated manner. The primary care provider of the HCPN will act as the navigator and coordinator of health care within the network.
LIPH	Local Investment Plan for Health	A medium-term public investment plan for health of LGUs with a three-year strategic timeframe. The plan covers the health operations of the locality and health sector activities and guides how health system outcomes will be achieved with specific LGU, DOH, and stakeholder actions.
MSU	Management Support Unit	A support unit of the P/CHB was created to support the board in managing the SHF, providing technical and administrative support to board operations, and coordinating with P/CWHS stakeholders.
P/CHB	Provincial/City Health Board	A board is organized in each local government (province/city) to steward and set policy and strategic directions for the P/CWHS.
PHO	Provincial Health Office	This is the office in charge of the health sector at the provincial level. With the UHC Law, the office is also designated as the technical secretariat of the PHB. Under the UHC law, the PHO oversees the operations and technical integration of the PWHS.
P/CWHS	Province/City Wide Health System	An integrated local health system composed of municipal and component city health systems (for PWHS) or highly urbanized/independent component cities (for CWHS). This includes the Provincial/City Health Office, facilities and services, human resources, and other health-related operations under the administrative and technical supervision of the Provincial/City Health Board (P/CHB).
SHF	Special Health Fund	A special fund pooling all financial resources at the P/CWHS intended to finance population- and individual-based health services, health system operating costs, capital investments, and remuneration of additional health workers and incentives for all health workers.
TMC	Technical Management Committee	This support unit under the PHO may be created to supervise sub-provincial health systems, as applicable.
TOP	Terms of Partnership	The legal instrument formalizes the DOH and LGU agreement to implement the AOP.

ANNEX B: COMPARISON OF FINANCIAL SYSTEMS FOR HEALTH AT PRESENT, ILHZ, AND PCWHS

	Present	ILHZ	PCWHS *Potential*	Recommendation to Improve Implementation of Financial Integration of PCWHS
Legal basis	LGU Code of 1991	Executive Order (EO) 205 s 2000	UHC Law 2019: RA 11223; Mandates of the LGU Code of 1991 for the health sector still apply	Close monitoring and evaluation of the impact of the UHC Law in the context of the LGU Code, PhilHealth Law, and other applicable policies
Financial oversight	Local Health Board	ILHZ Health Board and TMC	Provincial Health Board and MSU; Sub-provincial cluster/districts TMC, as needed; LHB of each tier of LGU will continue to give oversight to health financing of their LGU	The capacity of PHB/CHB and MSU, such as the LGU Finance Committee and accountants, need to be standardized and supported to ensure their capacity to implement their functions.
Local Health Financing				
Planning, Budgeting, and Allocation				
Planning and budgeting mechanisms	Each LGU plans for health services using the Local Investment Plan for Health (LIPH). This may or may not feed into the Annual Investment Plan of each LGU, which is the basis of the execution of the LGU's annual budget.	Annual Financial Plan of ILHZ but may be variable	LIPH will be the basis for the execution by the PCWHS of the SHF; the existing planning mechanism for each tier of LGU for health services still apply	Strengthen guidance for the LIPH, considering the financial integration of PCWHS. Review the appropriateness of the current format and processes of the LIPH vis-a-vis SHF as well as the health sector's current priorities. *If each LGU in a PCWHS continues to manage its funds for health, then there need to be mechanisms to ensure coherence among these.*
Technical scope	The LGU plans for its population based on jurisdiction. However, the health service delivery scope (whether primary or higher levels of care) is determined whether an LGU is a municipality, city or province.	Catchment area of the ILHZ for primary to tertiary care	Province or City-Wide Health System will provide primary to tertiary care services for its catchment population (exclusive of apex services); health service delivery scope per LGU tier level still applies	The Omnibus Health Guidelines of the DOH needs to be improved, converted to minimum technical standards for a PCWHS, and communicated to stakeholders. Referral and gatekeeping functions and standards need to be better included in the technical scope of PCWHS.
Fund sources considered	NTA and other monies generated at the LGU level, PhilHealth reimbursement, and DOH grants are also considered.	Variable for each ILHZ; some sources include LGU Counterpart, DOH Grants Development Partner support	UHC Law mandates PhilHealth to contract a network or networks in P/CWHS for individual-based health services with the exclusion of apex hospitals. It mandates PhilHealth to put all income for PCWHS in the SHF; DOH and LGUs will contract P/CWHS for population-	Continue to design and improve benefit packages, grants, and other funding mechanisms for health to consider the financial cycle of the PCWHS. For example, front-loaded and capped funds going into the SHF may ensure more efficient and

			based health services. The DOH and PhilHealth have already released initial guidelines illustrating the funding mechanisms of the SHF.	targeted use of the funds for health services by being more visible and predictable.
Fund pools	NTA and other monies generated through local taxation are put in the General Fund; PhilHealth reimbursements are put into Trust Funds per PhilHealth policy. DOH financial grants are put in Trust funds per DOH policy.	Different set-ups of Common Health Fund	Pooling and earmarking of resources of the Special Health Fund at the provincial or city-wide level; In the interim, individual LGUs may continue to fund health services from their individual general and trust funds.	Continue to create policies that will standardize and improve the implementation of the SHF at the PCWHS. Consider creating a standard manual of procedures (MOP) for the SHF, which PCWHS can adopt in its implementation.
Budget Execution				
General policies	The budget execution of LGU funds follows a similar process of appropriation, allotment, obligation, and disbursement. It is subject to the same policies relating to procurement and financing of the various inputs needed (e.g., Government Procurement Reform Act).	Dependent on the agreement of the ILHZ and the funder	According to the terms stipulated in the contracts (from PhilHealth and DOH) and other policies, such as the COA accounting rules and regulations, as overseen and implemented by a capable PHB/CHB and MSU. Existing PFM rules may still apply.	Closely monitor budget execution and diagnose and address any PFM-related bottlenecks
Hiring of health care workers (HCWs)	The policy on personnel service (PS) cap limits the number of health care workers hired through the general fund; LGUs may augment the hiring of contractual HCWs using monies from the trust fund. DOH HRH augmentation per cadre	--	Funds from the SHF can be utilized to hire additional contractual HCWs to complement the existing cadre of HCWs of LGUs in a PCWHS. This can also be used to provide additional incentives to HCWs in PCWHS. Each LGU will continue to hire HCWs as mandated by the LGU code.	Support PCWHS in using the SHF to hire sufficient workforce to supplement the existing staff of LGUs. Design of financial incentives for HCWs via the SHF is needed as well. Monitor and continue to address PFM limitations, such as ensuring permanent positions, adequate salary, and other incentives.
Payment for facility operational cost	Each LGU pays for operational costs for its facilities.		Each LGU will continue to pay for its owned facilities' recurrent operational costs (e.g., utilities). Funds from the SHF can be utilized to fund the non-recurrent operational costs.	Monitor and continue to address PFM limitations that deter the operations of each facility in a PCWHS.
Procurement of medicines and supplies	Each LGU procures its medicines and supplies for its constituents following general procurement rules. PhilHealth money can purchase medicines and supplies from the private sector through consignment. All public facilities can only purchase medicines in the Philippine National Drug Formulary (unless exempted) and follow corresponding procurement prices indicated in the Drug Price Reference Index. DOH gives in kind medicines, supplies, and commodities.	--	Funds from the SHF can be utilized to procure medicines and supplies for a PCWHS, primarily through pooled procurement or other mechanisms, which may lead to economies of scale. Only products that have gained the approval from the Health Technology Assessment Council may be procured by public entities. Other rules may still apply.	Provide technical assistance and other support to improve pooled procurement of medicines at the PCWHS, including capacity building and implementation of the eLMIS.

Subcontracting to the private sector	Each LGU follows general procurement rules or existing PPP mechanisms when engaging with the private sector to deliver health services.	--	Funds from SHF can be utilized to procure services from the private sector for a PCWHS. General procurement rules or existing PPP mechanisms may still apply.	Continue to design and support mechanisms that will ease and ensure the meaningful engagement of the private sector.
Health infrastructure development	Each LGU must source money to be able to build infrastructure for health. Most of these are through the Health Facility Enhancement Program (HFEP) of the DOH.	--	Funds from SHF can be utilized to fill in gaps in health infrastructure for a PCWHS.	Design or redesign the HFEP to support a PCWHS based on assessing its gaps anchored on DOH licensing and PhilHealth standards. Consider redesigning these licensing and accreditation standards and include the networked arrangement of PCWHS.
Governance activities, including policy development, strategies, and coordination	Each LGU, with respective health boards, provides resources for policy development and strategies for health. There is no mechanism to ensure coordination across LGUs	--	Funds from SHF can be utilized to fill in gaps in governance activities, especially the functioning of the PHO, TMC, and MSU.	Design technical assistance to support PCWHS in the policy development, strategies, and coordination of its network. Ensure that PCWHS can fund the governance activities needed for its health system, including a robust health information system architecture.
Monitoring and Evaluation				
Audit	The local COA does a yearly audit of the general trust fund but may or may not do an audit of individual trust funds.	--	The COA will audit the SHF based on policies from each fund source, including those from PhilHealth/DOH.	DOH/PhilHealth needs to work closely with COA to ensure the timely release and improvement of guidelines to ensure accountable use by the PCWHS of monies inside the SHF.
Others	DOH, DILG, DOF, and other government agencies are implementing various paper and electronic tools to monitor the LGU's utilization of its various funds. On the other hand, PhilHealth does not monitor or evaluate how LGUs utilize its reimbursements. Many gaps remain in terms of information on local health financing.	--	The UHC Law mandates the creation of an SHF tracking system.	Prioritize the development of the SHF tracking system and procedures for monitoring and evaluation. Consider designing technical assistance (TA) to support LGUs in adopting digital PFM mechanisms for the health sector to ease gathering health financial information. Ensure the capacitation of NGOs/CSOs who can monitor health financing at the PCWHs level.

ANNEX B: A FRAMEWORK TO CONCEPTUALIZE INTEGRATION

SOURCE: (Grépin and Reich 2008)

Domain	Type	Definition	Sample Application to Financial Integration of PCWHS
DOMAIN *What is being integrated?*	Activity	Joining core activities of separate programs.	Empanelment of beneficiaries to primary care facilities (e.g. Konsulta) at the PCWHS with support from participating LGUs and anchored on the network referral system
	Policy	Joining the policy functions of separate programs, such as advocacy, needs and priority assessment, technical and financial guideline development, and programming and coordination activities.	Strengthening the local policy generation capacity of the P/CHB; *Sangguniang* (Local Council) Resolution for the implementation of programs for the PCWHS.
	Organizational structure	Merging separate programs into a common structure or forming a new organization.	Creation of the PHB/CHB and MSU
LEVEL *Where is integration occurring?*	Global	Integration among the international partnerships and other international health organizations involved in the financing, planning, and implementing of disease-specific programs.	-------
	National/regional	Integration among national or regional disease-specific programs, various Ministry of Health (MOH) divisions, other relevant public sector offices, nongovernmental organizations (NGOs), and other national or regional partners.	Improved national policies of DOH and PhilHealth (e.g. Redesigning the outpatient benefit package of PhilHealth to one Comprehensive Outpatient Benefit Package based on Lifestage approach and Omnibus Health Guidelines.)
	Local (district/village/community)	Integration among the implementers, including MOH employees, NGOs, community volunteers, and relevant community-based partners	Financial integration of province- and city-wide health systems
DEGREE *How is integration occurring?*	Coordination	Communication and information exchange among distinct programs for the purpose of simplifying the implementation of the respective programs.	Aligning budget of PCWHS and component LGUs.
	Collaboration	Increased cooperation among disease-specific programs, which, in addition to increased coordination, could include the sharing of resources or personnel.	Joint implementation of the Konsulta program by LGUs in a PCWHS
	Consolidation	Implementation of a portion or an entire program by another program.	Pooled procurement of medicines by the PHB/CHB for a PCWHS.

ANNEX C: TYPES OF FINANCIAL INTEGRATION

SOURCE: (Mason et al. 2015)

Types	Definition
1. Transfer payment	Also known as grant transfer. Transfer payments allow local authorities to make service revenue or capital contributions to health bodies to support specific additional health services, and vice versa.
2. Cross charging	Mandatory daily penalties. Compensate for delayed discharges in acute care where social services are solely responsible and unable to provide continuation service.
3. Aligned budgets	Partners align resources, identifying own contributions but targeted to the same objectives. Joint monitoring of spend and performance. Management and accountability for health and social services funding streams remain separate.
4. Lead commissioning	One partner leads commissioning of services based on jointly agreed set of aims.
5. Pooled funds	Each partner makes contributions to a common fund for spending on agreed projects or services.
6. Integrated management/provision with pooled funds	Partners pool resources, staff, and management structures. One partner act as host to undertake the other's functions. Includes (but is not synonymous with) "joint commissioning" across health and social care.
7. Structural integration	Health and social care responsibilities combined within a health body under single management. Finances and resources integrated using the Health Act flexibilities.
8. Lead commissioning with aligned incentives	Reinvestment payments to providers based on quality of care and reduced costs of emergency care.